Mail

Utilitarianism and the perversion of the ethics of Hippocrates

To the Editor

In their guidelines for resolving conflict in cases of nonbeneficial or futile medical treatment, the San Francisco Bay Area Network of Ethics Committee continues the disturbing trend of medicine moving toward collectivism and the ethics of distributive justice.[1,2]

According to the tradition and ethics of Hippocrates that have served the profession well for 2500 years, physicians recognize that the interest of the patient is paramount. They, therefore, reject the so-called rational allocation of scarce and finite resources. Physicians who follow the ethics of Hippocrates place the interest of the individual patient above that of the collective, be that third-party payers, health care networks, or the "greater good" of society.[2] To do otherwise becomes the first step down the slippery slope of euthanasia—rationing by death.

Before the Nazis came to power in Germany, the Weimar Republic (a social democracy) paved the way for rational utilitarian ethics of the allocation of resources. As early as 1931, German physicians openly held discussions about the sterilization of "undesirables" and euthanasia of the chronically mentally ill. Hitler issued his first order for euthanasia in Germany on September 1, 1939. Organizations were set up for "health" programs under deceptively euphemistic terms. And so, before the Holocaust was officially implemented, 275,000 German citizens (non-Jews or Gypsies) were put to death.

Under the conflict resolution guidelines: "Nonbeneficial treatment is any treatment that, in the best judgment of medical professionals, produces effects that cannot reasonably be expected to be experienced by the patient as beneficial, or to accomplish the patient's expressed and recognized medical goals."[1(p287)] Under nonbeneficial treatment, the group writes: "Provision of indeterminate, long-term treatment to a patient who has no realistic chance of surviving outside an acute care hospital intensive care unit."[1(p287)]

Dr Leo Alexander, a psychiatrist and Chief US Medical Consultant at the Nuremberg war crimes trials, wrote: "If only those whose treatment is worthwhile in terms of prognosis are to be treated, what about the other ones? The doubtful patients are the ones whose recovery appears unlikely, but frequently if treated energetically, they surprise the best prognosticators."[3,4]

Physicians must be careful not to be used by social engineers as instruments to carry out a collectivist social agenda for rationing resources and deciding who lives and who dies. Although the concept of medical futility is indeed as old as Hippocrates, it was rejected then in favor of the moral tenor of "First do no harm," and it should be rejected now. To do otherwise would be to reject Dr Alexander's admonition that "from small beginnings the values of an entire society may be subverted."

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2 Faria MA Jr. The transformation of medical ethics through time, part I: medical oaths and statistical controls. *Med Sentinel* 1998;3:19-24.
3 Faria MA Jr. Euthanasia, medical science, and the road to genocide. *Med Sentinel 1998;3:79-83.*
4 Alexander L. Medical science under dictatorship. *N Engl J Med* 1949;241:39-47.

Author's response

The letter by Faria rails against our supposed attempt to sneak rationing into medical decision making. Strangely enough, however, nowhere in our article and guidelines is there any mention or even hint of "distributive justice," "social engineering," and certainly not the specter of "Nazism." Our group explicitly excluded financial considerations as a rationale for discontinuing or forgoing treatment. What we did seek to present was a procedure for increasing the number of informed people involved in decision making, not only to resolve conflict but to ensure that such decisions were being made on a medically sound basis and for compassionate reasons.

Physicians often make decisions to discontinue or forgo treatment at the end of life. Most such choices are made in concert with patients and/or their families and loved ones. For those relatively few cases where conflict persists, but the physician feels that the patient would not have wanted to be maintained in a twilight state between life and death and may even be suffering, sometimes "First, do no harm," indeed, must prevail. But harm can be subjective. Most Americans, given the choice, do not wish to be kept in a persistent vegetative state. Unfortunately, most Americans do not yet express such wishes beforehand through advance medical directives. Therefore, somebody has to make decisions, and physicians, being most likely to know patients' most accurate prognosis, sometimes have to take the lead here. They do so on behalf of their patients, not society or some other sinister interest. In fact, the most common criticism leveled at futility policies is that they might give physicians too much authority, not less.

Leo Alexander's analysis of the Nazi experience is, indeed, a landmark in modern medical history. More to the point, there is a large and growing literature on the ethics of futility in medicine and even an excellent popular book that concisely summarizes the issues.[1] Shouldn't one at least consider the nuances of the debate before aiming a specious shotgun at those who make an honest attempt to address the clinical and ethical realities of futility?

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Reference

1 Schneiderman L, Jecker N. *Wrong medicine: doctors, patients, and futile treatment.* Baltimore: Johns Hopkins University Press; 1995.

Beware of bosses bearing beverages

To the Editor

We investigated a presumptive food-borne outbreak in Los Angeles County with a surprise ending. On August 27, 1997, an emergency department reported an outbreak of acute illness to the Communicable Disease Control unit in Los Angeles County. The acute illness affected 13 of 16 workers from a night-time construction site. During the night, all 13 workers who had a drink provided by their employer became ill with symptoms that included dizziness, nausea, vomiting, rapid breathing, nervousness, and numbness of the upper body. One worker had fainted; two workers said they had experienced increased strength. Symptoms began 15 minutes to 3 hours after consumption of the drink. No illness occurred in at least two of the three workers who did not consume the drink (risk ratio for drink consumption = indefinite; $P < 0.01$). Laboratory tests of specimens taken at the emergency department showed that the ill workers had rhabdomyolysis, as verified by a raised creatine kinase concentration with normal MB level, and a urinary screening test result was positive for amphetamines. All the workers recovered without being admitted to the hospital.

Immediately before the crew's departure to the construction site, the employer had provided them with thermoses of a drink containing "herbal ingredients" and had advised them "not to drink too much." A sample of the drink tested negative for amphetamine, but it could not be guaranteed that the sample had not been replaced or tampered with. The symptoms and laboratory test results were consistent with taking amphetamines; the beverage was epidemiologically linked to the illnesses.

This is the first reported outbreak of amphetamine poisoning associated with consumption of a contaminated drink. Similar cases may arise, however. Since first quantified in 1995, the number of clandestine methamphetamine laboratories destroyed in California has risen steadily (K Yamada, California Environmental Protection Agency, written communication, April 1999) indicating an increasing use of this drug. Physicians might see other patients presenting with amphetamine overdose, even in unusual settings, and should consider this and other toxic causes in disease outbreaks suspected to be of food-borne or waterborne origin.

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